

決 裁	常務理事	事務長	担当

Health Insurance Notification of Name Change of Insured Person / Dependent (Corrections)

To the Western Digital Technologies Health Insurance Association

Insurance card code and number		Name of the insured person			Gender	Insured person's birth date			
					M · F	(Y)	(M)	(D)	
Assigned workplace and department (Bldg./Fl.)		Dependent's name (only if applicable)		Relationship	Gender	Type of household	Dependent's address (if living separately)		
HGST Japan Ltd. Telephone (Extension)					M · F	Living together · Living separately			
Name after change				Name before change					
Furigana				Furigana					
Last name		First name			Last name		First name		
Date of change			Reason for the change			Insured person's address			
(Y)	(M)	(D)				Telephone			

*Please be sure to attach the insured individual's insurance card.

Date of submission	(Y)	(M)	(D)	受付日付印
事業主の証明電	事業所所在地			
	事業所名			
電	事業主氏名			
	電話			
社会保険労務士の提出代行記載欄				